

MEDICAL REVIEW – NORTH II SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

**UNITEDHEALTHCARE COMMUNITY PLAN
OF CALIFORNIA, INC.**

2021

Contract Number: 17-94404

Audit Period: June 1, 2019
Through
May 31, 2021

Report Issued: November 22, 2021

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I. INTRODUCTION

UnitedHealth Group, Inc., a publicly traded company incorporated in 1977, operates on two business platforms. Health care coverage and benefit services are provided under the UnitedHealthcare branch, and information and technology-enabled health services are provided under the Optum branch.

UnitedHealthcare provides services to an array of customers in different markets under various companies. UnitedHealthcare Community and State is the segment that manages healthcare benefit programs for Medicaid across the United States. UnitedHealthcare Community Plan of California, Inc. (Plan), which was incorporated in March 2013, is the California segment for Medi-Cal.

The Plan obtained its Knox-Keene Health Care Service Plan license in October 2014 and contracted with the Department of Health Care Services (DHCS) in October 2017 as a Geographic Managed Care (GMC) plan to provide health care services to Medi-Cal beneficiaries in the GMC counties of Sacramento and San Diego.

The Plan left Sacramento County at the end of October 2018. As of July 9, 2021, the Plan's total Medi-Cal membership in San Diego County was approximately 23,673 members for the audit period.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the audit period of June 1, 2019 through May 31, 2021. The review was conducted from July 19, 2021 through July 30, 2021. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on October 19, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the preliminary audit findings. On November 3, 2021, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Improvement (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of April 1, 2018 through April 30, 2019) was issued on October 18, 2019. This audit examined documentation for contract compliance and assessed implementation of the Plan's 2019 Corrective Action Plan (CAP). The CAP closeout letter, dated July 14, 2020, noted that all findings were closed.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Plan's UM program, including delegation of UM, prior authorization review and the appeal process.

The Plan is required to include within the UM program mechanisms to detect both under and over-utilization of health care services. The Plan did not have written documentation that detects under and over-utilization of health care services.

The Plan is required to ensure prior authorization requirements are not applied to preventive services. The Plan required prior authorizations for preventive services.

The Plan is required to review and document the written record of appeals periodically by the governing body of the Managed Care Plan (MCP), the Public Policy Body, and by an officer of the MCP or designee. The Plan did not document the oversight of their appeals system.

Category 2 – Case Management and Coordination of Care

No findings were noted for the audit period.

Category 3 – Access and Availability of Care

Category 3 includes requirements to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) for members.

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) to determine the appropriate level of service for Medi-Cal members. PCS forms must include components such as dates of service needed, mode of transportation needed, and PCS of medical necessity. The Plan did not consistently obtain and track the required PCS forms for NEMT services.

The Plan's network providers must be enrolled in the Medi-Cal program. The Plan did not ensure its transportation vendor's NEMT providers were enrolled in the Medi-Cal program.

Category 4 – Member's Rights

Category 4 includes requirements to establish and maintain a grievance system, the handling of protected health information, and requirements for the Plan's Cultural and Linguistic Services Program.

The Plan is required to aggregate and analyze grievance data, on a quarterly basis, for QI. Grievance data shall include access to care, quality of care, and denial of services and appropriate action shall be taken to remedy problems identified.

The Plan did not take appropriate action to remedy problems identified related to grievances and appeals.

The Plan is required to ensure that the written record of grievances and appeals is periodically reviewed by the governing body, the public policy body, and by an officer of the Plan or designee. The review shall be thoroughly documented. The Plan's governing body, the public policy body, and officer or designee did not review and document the review of the written record of grievances and appeals.

Category 5 – Quality Management

Category 5 includes procedures and requirements to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by providers.

The Plan is required to conduct training for all new providers (physician and non-physician) within ten working days after the Plan places a newly contracted provider on active status. The Plan did not ensure that all network providers conducted training for newly contracted providers within ten working days of placing them on active status.

Category 6 – Administrative and Organizational Capacity

Category 6 includes maintaining a health education system that provides educational interventions and maintains a compliance program to guard against fraud and abuse.

The Plan is required to maintain a health education system that provides educational interventions. The Plan did not offer educational interventions for unintended pregnancy, complementary care, and alternative care.

The Plan is required to implement a method to verify whether services were delivered by network providers, and apply the verification processes on a regular basis. The Plan did not implement a method to verify services delivered by network providers.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted the audit to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

DHCS conducted an audit of the Plan from July 19, 2021 through July 30, 2021. The audit included a review of the Plan's Contract with DHCS, its policies and procedures for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. DHCS reviewed the Plan's documents and conducted interviews with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 66 medical and 31 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriateness of review.

Prior authorization appeal procedures: 20 prior authorization appeals (14 medical and six pharmacy) were reviewed for appropriateness and timeliness of decision-making.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): Six member records were reviewed to ensure the Plan's adherence to policies and procedures for identifying and referring members with CCS eligible conditions and to ensure that the Plan is in compliance with Contract requirements for monitoring the coordination of care for members.

Complex Case Management (CCM): 15 medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources for members who received CCM services.

NMT and NEMT: 30 member records (15 NEMT and 15 NMT) were reviewed for completeness and compliance with the Contract.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 15 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance System: 61 quality of service and 40 quality of care grievances were reviewed for timely resolution, response to complaint, and submission to the appropriate level for review.

Confidentiality Rights: Two Health Insurance Portability and Accountability Act cases were reviewed for appropriate reporting and proper processing.

Category 5 – Quality Management

New Provider Training: 16 new provider training records were reviewed for timeliness.

Potential Quality of Care Issues: Five cases were reviewed for reporting, investigation, and remediation.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 20 fraud and abuse cases were reviewed for appropriate reporting and processing within the required timeframes.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthcare Community Plan of California, Inc.

AUDIT PERIOD: June 1, 2019 through May 31, 2021

DATE OF AUDIT: July 19, 2021 through July 30, 2021

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM
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1.1.1 Over and Under-Utilization of Health Care Services

The Plan is required to include within the UM program mechanisms to detect both under and over-utilization of health care services. *(Contract, Exhibit A, Attachment 5(4))*

Finding: The Plan did not have written documentation that detects under and over-utilization of health care services.

There is no policy to document mechanisms that the Plan implements in assessing its UM data for detection of under and over-utilization of medically covered services in a systematic manner. The Plan submitted Policy CAQI-002 Quality and Performance Improvement Requirements and Reporting as their response for the detection of over and under-utilization of health care services. This reflects that the Plan relies on DHCS selected Medi-Cal Accountability Set / External Accountability Set (MCAS/EAS) measures of under-utilized services for its identification. The Plan also did not identify any under-utilized services outside of the MCAS/EAS measures during interviews. The Health Quality UM Committee minutes also highlighted only the MCAS/EAS measures and did not document any new detection of under-utilized services.

The Plan's failure to review UM data and document its mechanisms for detecting under and over-utilization inhibit the Plan's ability to ensure a healthier population and that proper care is delivered to the proper member at the proper time.

Recommendation: Develop and implement policies and procedures to include mechanisms that detect both under and over-utilization of health care services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthcare Community Plan of California, Inc.

AUDIT PERIOD: June 1, 2019 through May 31, 2021

DATE OF AUDIT: July 19, 2021 through July 30, 2021

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorization Requirements and Preventive Health Care services.

Prior authorization requirements shall not be applied to emergency services, minor consent services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and Human Immunodeficiency Virus (HIV) testing. (*Contract, Exhibit A, Attachment 5(2)(H)*)

The Plan shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the Initial Health Assessment or during visits for routine, urgent, or emergent health care situations. The Plan shall ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up. (*Contract, Exhibit A, Attachment 10(6)(B)*)

Findings: The Plan required prior authorizations for preventive services.

The Plan had no controls in place to prevent prior authorization requirements for preventive care for lung cancer screening. The sub-delegate performing prior authorizations was unaware that prior authorization requirements did not apply to preventive services.

Verification studies revealed that prior authorization services were performed for 44 lung cancer screenings during the audit period. These requests underwent a prior authorization process despite being identified as a preventive screening.

The addition of prior authorization requirements on preventive health services places an additional barrier and potential delay in diagnosing problems. Erecting barriers to screening may deter providers from ordering the screening tests and members from seeking care.

Recommendation: Ensure that prior authorization requirements are not a prerequisite for preventive services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: UnitedHealthcare Community Plan of California, Inc.

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1.3

PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Review of the Written Record of Appeals

The written record of appeals shall be reviewed periodically by the governing body of the MCP, the Public Policy Body, and by an officer of the MCP or designee. The review shall be thoroughly documented. (*All Plan Letter (APL) 17-006 Grievance and Appeal Requirements*)

Finding: The Plan did not document the oversight of their appeals system.

The Plan policy, *CAOPS126 Member Appeal Grievance Policy State Fair Hearing and Independent Medical Review Policy*, did not require that the Plan's governing body, public policy body, and officer or designee shall periodically review, and thoroughly document the review of the written record of grievances and appeals.

There was no attestation from the governing body of the Plan, public policy body and by an officer of the Plan documenting a review of the written log for appeals. Review of the governing body and public policy meeting minutes did not contain a review of the written log of appeals during the audit period. During the interview the Plan stated that they did not perform the review of the written log.

Without adequate review of the appeal logs, the members may suffer increased morbidity through the denial or delay in receiving timely needed medical services.

Recommendation: Develop and implement a periodic review of documentation of the written record of appeals by the governing body of the MCP, the public policy body, and by an officer of the MCP or designee.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION
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3.8.1 Physician Certification Statement Form Requirement

The Plan shall cover NEMT services required by members to access Medi-Cal services, as provided for in Title 22 CCR Section 51323, subject to contractor’s PCS form being completed by the member’s provider.

(Contract A01, Exhibit A, Attachment 10(8)(H)(2))

APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services (6/29/17; Revised 9/8/20), states that the Plan must use a DHCS-approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member’s treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum: function limitations justification, dates of service needed, mode of transportation needed, and certification statement. The Plan must have a mechanism to capture and submit data from the PCS form to DHCS.

The Plan policy, *CA OPS 130 Transportation Services* (effective April 26, 2021), states that PCS forms are required for NEMT services. The Plan uses the DHCS approved PCS form which includes functional limitations, prescribed dates of service, and prescribed mode of transportation. The PCS forms are to be used by the transportation vendor to obtain the mode of transportation from the treating physician to authorize NEMT services and standing orders prior to rendering services. Once the member’s treating physician prescribes the form of transportation, the authorized PCS form cannot be modified. The approved PCS form includes the certification statement (prescribing physician’s statement certifying that medical necessity was used to determine the type of transportation being requested). PCS forms can be used for NEMT services that include but are not limited to, medical, dental through Denti-Cal, mental health, substance use disorder, specialty mental health, durable medical equipment, medical supplies, pharmacy trips for medications carved-out under Medi-Cal Rx and any other services delivered through Medi-Cal and the Plan.

Finding: The Plan does not complete the DHCS-approved PCS form as requirement for the provision of NEMT services.

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The Plan did not provide evidence that they implemented their policy and procedure for utilizing PCS forms to determine the appropriate level of service for members.

In a verification study, the Plan did not document the use of PCS forms for 12 of the 15 NEMT trips requiring PCS forms.

In an interview, the Plan reported that the transportation vendor is responsible for obtaining the PCS form prior to rendering services. The Plan does not delay transportation services while trying to obtain the PCS form. The Plan submits monthly reports to DHCS using trip log data instead of information from the PCS form as required by *APL 17-010*. Additionally, the Plan stated that it does not currently track PCS completion.

When the Plan does not gather PCS forms, the Plan cannot ensure that it complies with DHCS requirements to provide justification for medically necessary services.

Recommendation: Revise and implement policies and procedures to ensure the Plan uses the PCS form to determine the appropriate level of service for members.

3.8.2 Medi-Cal Enrollment of NEMT and NMT Providers

The Plan is required to comply with all policy letters, and APLs issued by DHCS. All Policy Letters and APLs issued by DHCS subsequent to the effective date and during the term of the Contract shall provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation. (*Contract, Exhibit E, Attachment 2(1)(D)*)

APL 19-004, Provider Credentialing and Re-credentialing and Screening and Enrollment (06/12/2019), states that MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division or another state department with a recognized enrollment pathway. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway.

Finding: The Plan did not ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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In a verification study, 15 NEMT trips were serviced by a total of ten providers. Six NEMT trips were serviced by six providers not enrolled in the Medi-Cal program. Two NEMT providers had National Provider Identifications with locations outside of California.

In an interview, the Plan clarified that its Contract with the transportation vendor requires that all federal and state laws are adhered to. The Plan explained that the vendor checks monthly to ensure their providers are included in the DHCS list of enrolled providers. The Plan allows a provider to participate in its network pending the outcome of the screening and enrollment process, in accordance with APL 19-004 and Title 42 of the Code of Federal Regulations (CFR), Section 438.602(b)(2). Following a “denial” of an enrollment application, the provider is discontinued from participating in the network. The Plan does not periodically track the outcome of enrollment applicants to ensure that denied providers are discontinued from the network. Additionally, the Plan explained that it has not looked into overpayment recoveries related to claims from unenrolled transportation providers.

If transportation providers are not enrolled in the Medi-Cal program, they may not meet state licensing and safety requirements resulting in members receiving unsafe transportation.

Recommendation: Develop and implement policies and procedures to monitor and ensure that new and existing NEMT providers meet the Medi-Cal enrollment requirements.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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4.1.1 Appropriate Action to Remedy Identified Grievance Problems

The Plan is required to compile the systematic aggregation and analysis of grievance and appeal data and use for QI. (Contract, Exhibit A, Attachment 14 (1)(J))

The Plan is required to submit the written record of grievances and appeals at least quarterly to the MCP’s quality assurance committee for systematic aggregation and analysis for QI. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified. (*APL 17-006, VII. Grievance and Appeal System Oversight (G)*)

The Plan policy, *CAOPS126 Member Appeal Grievance Policy State Fair Hearing and Independent Medical Review Policy*, states that reporting to the Board of Directors occurs quarterly for review. Additionally, the Board of Directors discuss and recommend actions by the Board to the Quality Department. Reporting included grievance and appeal volumes and trends as well as any health plan actions taken regarding trending issues.

Finding: The Plan did not take appropriate action to remedy problems identified related to grievances and appeals.

Although the Plan aggregated and analyzed its grievance data, it did not subsequently address or implement interventions for top grievance issues. The Plan’s QI committee evaluated grievance issues by discussing summary reports, but the minutes did not delineate actions taken to remedy grievance issues.

In an interview, the Plan stated that it performed appropriate action through interventions such as semi-annual evaluations and root cause analysis. The Plan submitted committee minutes to demonstrate interventions related to top grievance issues, such as quality of care internal referral mechanisms. However, the actions listed in the interventions section were general, and did not specify action to remedy specific grievance problems. For example, interventions listed for quality of care internal referral

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mechanisms included the following: concurrent intervention, ongoing monitoring, and disciplinary actions. However, the actions did not detail a remedy or QI plan.

The lack of appropriate actions to remedy identified grievance issues may prevent the Plan from improving systemic issues, which may have a detrimental effect on members' quality of care or quality of service.

Recommendation: Revise and implement policies and procedures to ensure appropriate action to remedy grievance problems identified.

4.1.2 Review of the Written Record of Grievances

The Plan is required to ensure that the written record of grievances and appeals is periodically reviewed by the governing body, the public policy body, and by an officer of the Plan or designee. The review shall be thoroughly documented.
(APL17-006, VII. Grievance and Appeal System Oversight (H))

The Plan policy, *CAOPS126 Member Appeal Grievance Policy State Fair Hearing and Independent Medical Review Policy*, did not require that the Plan's governing body, public policy body, and officer or designee shall periodically review, and thoroughly document the review of, the written record of grievances and appeals.

Finding: The Plan's governing body, the public policy body, and officer or designee did not review and document the review of the written record of grievances and appeals.

In an interview, the Plan stated that the Medical Director periodically reviewed the grievance logs. However, the Plan was unable to provide evidence showing the Medical Director, the governing body, and the public policy body reviewed the grievance logs.

The Plan's grievance policies and procedures did not delineate a periodic review of the written record of grievances and appeals.

Without adequate review of the grievance logs, the Plan cannot appropriately categorize grievance cases, which may lead to an adverse impact on member health due to potential missed intervention opportunities.

Recommendation: Revise and implement policies and procedures to ensure that the Plan's governing body, the public policy body, and Plan designee, review and document the review of the written record of grievances.

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CATEGORY 5 – QUALITY MANAGEMENT

5.3 PROVIDER QUALIFICATIONS

5.3.1 New Provider Training Requirement

The Plan is required to ensure that all network providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. Contractor shall conduct training for all network providers within ten working days after contractor places a newly contracted network provider on active status. (*Contract Amendment A05, Exhibit A, Attachment 7(5)(A)*)

Finding: The Plan did not ensure that all network providers conducted training for newly contracted providers within ten working days of placing them on active status.

A verification study of 16 new provider training records was conducted (eight from two delegated entities and eight contracted providers) revealed the following deficiencies:

- Of the eight contracted providers reviewed:
 - Six of the eight training records reviewed were not completed within the ten working days requirement.
- Of the eight delegated entity providers reviewed:
 - Eight of eight provider training records requested were not submitted because the Plan did not track and acquire attestations.

During the interview, the Plan stated that the delegated entity's "new providers" were not being tracked by the Plan for this time requirement. The Plan's policy and procedure, *CA OPS 304 Provider Training and Outreach Plan* and *PR-001 Rady Provider Education*, states that providers must conduct training within ten working days of the effective date of becoming a network provider. However, the Plan did not provide oversight and ensure these trainings were done by obtaining attestations that confirm adherence to the new provider training within the required timeframe.

The Plan discovered the issue of delegated entities not ensuring that new providers were completing their training within the ten working days as required in the 4th quarter of 2020 CA Mock Audit.

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During the audit period the Plan did not demonstrate that all network providers are trained within ten working days after the providers were placed on active status. This may result in delays in providing quality service to members. Without documentation of new provider training, the Plan cannot ensure providers operate in full compliance with the Contract and may result in the inefficiency of operations and lack of compliance with applicable statutes and regulations.

This is a repeat of prior year finding 5.2.1 – New Provider Training.

Recommendation: Develop and implement policies and procedures to ensure that all network providers are trained within ten working days of being placed on active status.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	HEALTH EDUCATION PROGRAM
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6.1.1 Health Education Program Interventions

The Plan shall maintain a health education system that provides educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by providers and also upon the member's request. Educational interventions designed to assist members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care. (*Contract, Exhibit A, Attachment 10(7)(a)*)

Educational interventions designed to assist members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/Acquired Immunodeficiency Syndrome, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting. (*Contract, Exhibit A, Attachment 10(7)(b)*)

The Plan Policy, *CAHECL-002 Health Education Program Policy*, did not require the educational interventions stipulated in the Contract.

Finding: The Plan did not offer educational interventions for unintended pregnancy, complementary care, and alternative care.

In response to audit questions, the Plan indicated that it did not provide health education interventions for unintended pregnancy, complementary care, and alternative care. The educational interventions were not listed on the Plan's website, Member Handbook, or Provider Handbook. The Plan did not submit evidence showing that it worked with providers to deliver these health educational interventions.

In an interview, the Plan confirmed that the health program did not provide educational interventions related to unintended pregnancy and complementary and alternative care.

The lack of the required educational interventions may affect members' effective use of managed health care services and can adversely affect members' health.

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Recommendation: Revise and implement policies and procedures to ensure that the Plan provides the required health interventions through its Health Education Program.

6.2 FRAUD AND ABUSE

6.2.1 Verification of Services Delivered by Network Providers

The Plan is required to have a provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and apply the verification processes on a regular basis. (*Contract 17-94404, Exhibit E, Attachment 2(25)(B)(5)*)

The Plan Policies, *CA OPS 127 California Fraud Waste and Abuse Reporting* (effective November 1, 2019) did not require a method to verify whether represented services by network providers were received by members as required in the Contract.

Finding: The Plan did not implement a method to verify services delivered by network providers.

During an interview, the Plan confirmed that it did not have a method in place to verify services delivered by network providers, and did not provide documentation to support a method in place.

Not verifying if services were delivered by network providers may result in missed detection of potential fraud instances related to Medi-Cal member services.

Recommendation: Revise and implement policies and procedures to verify services have been delivered by network providers and received by members.

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2021

Contract Number: 17-94405
State Supported Services

Audit Period: June 1, 2019
Through
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II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

This report presents audit results for UnitedHealthCare Community Plan of California, Inc. (Plan) State Supported Services Contract No. 17-94405. The State Supported Services Contract covers contracted abortion services with the Plan.

The audit was conducted from July 19, 2021 through July 30, 2021. The audit period was June 1, 2019 through May 31, 2021 and consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on October 19, 2021. There were no deficiencies found.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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STATE SUPPORTED SERVICES

The Plan's policies and procedures, Provider Manual, and Member Handbook were reviewed for the provision of State Supported Services.

The Plan had policies and procedures in place to provide abortion services to members. Members are informed of these services through the Member Handbook. Providers are informed of their responsibility to provide abortion services without prior authorization through the Plan's Provider Manual.

A verification study of 15 State Supported Service claims was conducted to determine appropriate and timely adjudication of claims. There were no systemic compliance issues identified in the verification study.

There were no deficiencies identified in this audit.

Recommendation: None